Corrections Quarterly Summary

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The *Corrections Quarterly Summary* is prepared by staff of L.I.S., Inc., for the U.S. Department of Justice, National Institute of Corrections. To submit questions or comments, please write to the NIC Information Center, 1790 30th Street., Suite 130, Boulder, Colorado, 80301, or call (303) 939-8877.

QUARTERLY SURVEY: Substance Abuse Treatment Programs

The survey for this quarter sought information about agencies' substance abuse treatment programs for offenders. Specifically, the survey requested information on the proportion of inmates needing treatment who are receiving it, methods of identifying inmates who need substance abuse treatment, methods of coordinating inmate profile data with treatment, and, finally, the types of treatment programs provided, including those targeted to specific offender populations.

Proportions of Inmates Needing/Receiving Treatment

Table 1, on page 11, lists inmate population figures from the BJS table on page 1. This was necessary because the survey question seeking data on total inmate populations during 1989 was interpreted in a variety of ways. Therefore, percentages in column two should not be seen as related to figures in column one. In addition, respondents reported for column two a mix of both numbers and percentages of inmates identified as needing treatment. These are clearly estimates in some cases.

Column three shows the percentage of those inmates identified as needing substance abuse treatment who actually received it. The percentages range widely among the twenty-five agencies that responded to this question. While **North Dakota, Iowa,** and the **District of Columbia** indicated that more than 90 percent of inmates needing treatment received it, other agencies provided treatment to 10 percent or fewer of inmates assessed as in need of treatment: **Illinois, Michigan, West Virginia,** and **Kentucky.** A majority of states were able to provide treatment to fewer than 40 percent of those who needed it.

Note that the survey did not request a uniform definition of "treatment." At least one explanation for the disparity among state responses to this question is that while one state may include as treatment self-help groups, another state may define only intensive in- or out-patient programs as treatment.

Use of Objective Screening Instruments

States also vary in the degree to which they rely on objective screening instruments to identify offenders who need treatment for substance abuse. The survey asked respondents to indicate whether they use objective or subjective screening methods and to identify the objective screening instruments used by their agencies.

All objective screening instruments identified by respondents are listed in Table 2, page 12, whether they screen for addiction severity, risk, or criminal history. Also included are instruments used in agency classification systems that were identified by the survey respondents as "objective."

Coordination of Inmate Profile Data and Assignments to Treatment

Responding agencies use data from their initial screening of inmates in a variety of ways. Coordination of screening data and treatment ranges from very informal systems to those in which inmate profile data directly drive the process of treatment referral.

A number of survey respondents pointed to the fact that because of shortages of space and treatment resources, provision of treatment cannot always be directly tied to assessed need. As a respondent from Georgia pointed out, "Security and bedspace issues must take precedence over programmatic assignments, which means that program assignments are sometimes weakly correlated with needs."

Agencies' descriptions of how their treatment programs are coordinated with offenders' profiles are provided in Table 3, pages 13-14.

Substance Abuse Treatment Programs Provided by State Corrections Agencies

The survey asked respondents to indicate the types of substance abuse treatment programs provided by their agencies. Some respondents gave details, including numbers, specific program descriptions, and names of institutions. Others attached brochures describing their programs, and still others provided only a casual listing of some general types of programs.

Despite these disparities in response, the survey results indicated that the substance abuse programs provided by correctional agencies range from minimal to long-term, intensive inpatient programs. Of forty-seven responding agencies, the majority indicated that they offer self-help groups such as Alcoholics Anonymous and Narcotics Anonymous (thirty-nine respondents), education programs (thirty-eight), and group counseling (thirty-nine). In some agencies, these approaches are part of extensive outpatient programs; in others, they are stand-alone programs.

Listed in Table 4, page 15-16, ate agencies' substance abuse programs that *do not* fall into one of the above categories. In addition to intensive in-patient programs, these include programs targeted for specific offender populations. Where programs listed by respondents fit in more than one category (e.g., a therapeutic community for women), they are included in both categories.

Other New or Proposed Programs

- The **Illinois** Department of Corrections is completing negotiations with the state Department of Alcholism and Substance Abuse to fund two adult male therapeutic communities within institutions and to expand services within the women's prison and to work release centers.
- **California** is beginning a three-year demonstration program in San Diego County, which will include a substance abuse treatment program at the R.J. Donovan Correctional Facility and a continuation of services within the community.
- **The Florida** Department of Corrections has proposed the development of a statewide system of regional drug intervention centers to house minimum or medium custody inmates assessed as needing substance abuse treatment, especially those convicted of drug offenses, theft, or burglary with sentences of five years or less. The first of these centers, the Martin Drug Intervention Center, will provide programming for designated minimum to medium security offenders of all ages. It will initially house 140 to 160 inmates. The entire facility will focus on drug treatment programming based on the therapeutic community model. The format will be modified from the regular nine- to twelve-month T.C. model to a more intensive four-month program.
- **In Kentucky, the** Division of Mental Health has received a grant from NIC to conduct a needs assessment; the Corrections Cabinet has appointed a task force on substance abuse.
- **Louisiana** recently received a three-year federal grant through joint effort of Department of Health and Hospitals and the Department of Correction; the program will focus on education and treatment of inmates at each adult institution.
- **Oklahoma is** proposing for fiscal year 1991 two labor camps, each housing 300 inmates convicted of drug offenses.

Conclusion

This survey, only one of many recently undertaken on this topic, has some limitations which have already been noted. However, as part of the *Corrections Quarterly Summary*, its purpose is simply to facilitate information-sharing among correctional administrators rather than provide detailed information for analytic or comparative purposes. Detailed descriptions of programs cited here, as well as many others, are available from the NIC Information Center at *(303) 939-8877.*

Table 1: State Correctional Facility Inmates Needing Substance Abuse Treatment

	Prison Population Dec. 31, 1989 (Source: BJS)	Inmates Assessed as Needing Treatment	Percent of These Inmates Receiving Treatment
Alabama	13,907	5,800	39%
Alaska	2,744	(90%)	20%
Arizona	13,251	N/A	N/A
Arkansas	6,409	(80%)	75%
California	87,297	N/A	N/A
Colorado	7,318	6,844 (76%)	31%
Connecticut	9,301	8,057	N/A
Delaware	3,365	3,145 (90–95%)	20%
Florida	39,999	20,359	31%
Georgia	20,885	(75% or fewer)	18%
Hawaii (N/A)	2,470		
Idaho	1,850	(85%)	N/A
Illinois	24,712	15,000	10%
Indiana	12,341	8,300 (70%)	12%
Iowa	3,584	1,810	91%
Kansas	5,622	1,676	87%
Kentucky	8,289	(90%)	0%
Louisiana	17,257	N/A	N/A
Maine	1,455	1,400	N/A
Maryland (N/A)	16,514		
Massachusetts	7,524	6,487 (70–80%)	45%
Michigan	31,746	(80%)	10%
Minnesota	3,103	N/A	N/A
Mississippi	7,911	(80%)	50%
Missouri	13,919	N/A	N/A
Montana	1,362	960	21%
Nebraska	2,438	494	N/A
Nevada	5,387	(80%)	N/A
New Hampshire	1,166	850	47%
New Jersey	19,439	N/A	N/A
New Mexico	3,034	(85–87%)	N/A
New York	51,227	37,913	39%
North Carolina	17,451	10,469 "moderate to severe"	N/A
North Dakota	451	295	100%
Ohio (N/A)	30,538		
Oklahoma	11,423	(60–70%)	N/A
Oregon	6,744	N/A	N/A
Pennsylvania	21,267	(65–70%)	N/A
Rhode Island	2,479	N/A	N/A
South Carolina	15,720	7,138	82%
South Dakota	1,277	568	25%
Tennessee	10,621	(80%)	20%
Texas	40,789	34,771	N/A
Utah (N/A)	2,378		
Vermont	896	441	N/A
Virginia	16,477	10,817	25%
Washington	6,928	5,355 (80%)	22%
West Virginia	1,536	300	8%
Wisconsin	6,788	(65–70%)	N/A
Wyoming (N/A)	1,026		
District of Columbia	9,268	(85%)	90%
Federal Bureau of Prisons (N/A)	59,171		
Canada	13,000	(53.7%)	N/A

Table 2: Objective Screening Instruments Used by Responding States

State/Agency	Instrument(s) Used
Arizona	Agency classification system.
Arkansas	Minnesota Multiphasic Personality Inventory (MMPI).
California	Agency classification system.
Colorado	Drug Abuse Screening Test (DAST).
Connecticut	Agency classification system.
Florida	Addiction Severity Index (ASI), Readiness for Treatment (RFT).
Indiana	MMPI (McAndrews Scale), Subtle Alcoholism Screening Inventory (SASI).
Kansas	MMPI (McAndrews), Carlson Psychological Inventory.
Maine	Agency-developed grid ranking/scoring sheet.
Massachusetts	ASI, Michigan Alcoholism Screening Test (MAST), Mortimer-Filkin, Fowler Correctional Index.
Michigan	(Various), MMPI.
Missouri	Agency classifiction system.
Montana	MMPI, Millan Clinical Multi-Axial Inventory (MCMI), Montana State Prisons chemical dependency questionnaire.
New Hampshire	Mortimer Filkins, MMPI, Johns Hopkins Questionnaire, CASAS.
New Jersey	ASI.
New Mexico	MMPI, mandatory urine testing on arrival.
New York	MAST.
North Dakota	MMPI, DSM IIIR.
Oregon	Agency-developed instrument that is a variation of Screening/Triage Form from Narcotics and Drug Research, Inc. (NDRI); agency risk classification instrument.
South Dakota	MAST, DSM IIIR.
Texas	Agency-developed instruments.
Vermont	Agency classification system.
Virginia	Agency-modified NIC classification system.
Washington	MAST, Chemical Dependency Profile, DAST, Revised Jellinek.
West Virginia	MMPI (McAndrews).
Wisconsin	Alcohol Dependency Scale (ADS), offender drug use history questionnaire.
Canada	DAST, ADS.

Table 3: Coordination of Offender Profile Data with Treatment

Alabama	Profile data are entered on drug screen weekly and reports are issued to Treatment Services that compile information from drug screens.
Arizona	Correctional Program Officer has responsibility to encourage inmates to address all program needs. No accountability system to measure how well this is being done.
Arkansas	Coordination is by unit classification committee, including manager of substance abuse treatment program.
Colorado	Severity ratings drive treatment referral and priority of treatment. Management reports show severity by treatment received; these are used to manage resources.
Delaware	Agency tries to match critical needs with program openings; only those with serious problems get treatment.
Florida	Inmates are assigned to programs based on scores on objective instruments.
Georgia	Program assignments are made by institution and counseling staff. Security and bedspace issues generally take precedence over these assignments.
Idaho	Port of Hope staff conduct informal needs assessments, make recommendations for AA/NA classes, and conduct classes for eligible inmates. Eligibility is affected by custody level.
Illinois	Inmates identified as needing services are contacted by institution-based counselors responsible for substance abuse education. All institutions have such counselors.
Indiana	Data collected in diagnostic center are included in the confidential section of the offender packet and reviewed by treatment staff. A new checklist will be in place by September 1990 to provide quick identification of treatment needs and data for program planning.
Iowa	Projected time to be served is coordinated with custody level to estimate the availability of space along with the need for the program.
Kansas	Offenders are assigned a severity level based on initial screening, treatment is based on severity.
Kentucky	Currently there are only self-help groups; agency is developing a comprehensive, system-wide program.
Maine	Inmates are referred by the classification committee after initial intake and assessments.
Massachusetts	Treatment per se is not coordinated with profile data. Contracted treatment provider examines criminal history as part of treatment plan.
Michigan	Database is merged with MIS output; an evaluation system was developed by all publicly-funded substance abuse programs statewide.
Minnesota	Coordination is done through a program review team that includes caseworkers and facility program staff with expertise in chemical dependency assessment skills.
Mississippi	Agency has a thirty-day program for evaluation with continuation if needed, need is determined by drug and alcohol unit staff. Parole monitoring is done by drug and alcohol counselors throughout the state.
Missouri	Agency uses an automated offender MIS.
Montana	Initial classification committee makes referral recommendations to various programs.

Table 3. Coordination of Offender Profile Data with Treatment, cont.

Nebraska	Institution's records office generates passes for inmates to attend initial orientation services. Inmates may volunteer for an m-patient program or if anticipating transfer may wait and apply for a less intensive outpatient program at another facility. Classification data are used in preparing reports and planning treatment after inmates are accepted into a program.
Nevada	Recommendations are made by intake psychiatric staff.
New **Hampshire**	Treatment scores are generated according to guidelines from the classification manual. Treatment is based on need; inmates must request treatment and demonstrate motivation.
New Jersey	For the therapeutic community, the Addiction Severity Index is used to develop a structured treatment plan.
New Mexico	Mental health staff are members of classification committees; they administer tests, analyze results, and prepare recommendations for treatment/programs.
New York	Classification information is used by treatment staff at transfer facility.
North Carolina	A case analyst recommends treatment for identified problems and refers inmates to mental health, medical, educational, vocational, or other services, as appropriate.
North Dakota	Treatment is coordinated through intake assessment and evaluation.
Oklahoma	Treatment depends on program space and offender needs; a needs assessment process, including educational testing and self reporting, is used.
Oregon	Counselors use a screening instrument in conjunction with file information to establish a need rating, which is considered in referral for treatment.
Pennsylvania	An in-house risk assessment and subjective diagnostic tools are used in placement.
Rhode Island	A substance abuse program coordinator consults with counseling staff and private agencies contracted to provide substance abuse services.
South Dakota	The screening process determines offender suitability for a voluntary treatment program.
Texas	During diagnostics, classification staff collect data on substance abuse history, which are provided to the unit re-classification committee, which refers inmates to the substance abuse treatment program for further screening and possible placement in the program.
Vermont	Inmates are referred on a case-by-case basis. They must participate in programming if they have Level IV needs in sexual behavior or Level EEE or IV in alcohol, drug abuse, emotional stability, and/or violence proneness.
Virginia	Offender profile data are coordinated with treatment through the use of initial and institutional treatment plans and progress reports.
Washington	Treatment is coordinated through unit team recommendations and staff referrals.
west Virginia	Scores from classification systems are used to coordinate treatment.
Wisconsin	Based on objective assessment scores, inmates are offered treatment programs specifically designed to meet their needs in both intensity of drug use and degree of criminality.
D.C.	Coordination is through classification and case management process.
Canada	Coordination is through case management officers and uses a lifestyle screening instrument

Table 4. Treatment Programs Provided

Therapeutic Communities

- **Alabama** - fifty beds.
- Florida-eight-week modified program; nine- to twelve-month programs for males, females, male youthful offenders.
- **Georgia** - to-four-week modified program for offenders not in system long enough for more intensive program; six- to twelve- month full program.
- Illinois - females only.
- **Massachusetts - four units.**
- **Montana**
- **Nebraska**
- **New Hampshire**
- **New Jersey**
- **New Mexico**
- **New York**
- **Oregon**
- **Vermont - modified; one** unit each for males and females; one for males at field unit.

Programs for DWI Offenders

- **Arizona - three** DWI facilities.
- Iowa-for third-time offenders, a three-week evaluation followed by six months' treatment in the community.
- **Massachusetts-state-run facility** for multi-driving offenses.
- Oklahoma - thirty-to sixty-day residential program; joint project of the Department of Mental Health and the Department of Correction

Other Intensive, Inpatient Programs

- **Iowa**
- **Kansas**
- **Massachusetts**
- **Michigan**
- **Minnesota**
- **Mississippi**
- **Missouri**
- **Montana**
- **Nebraska**
- **New Hampshire - new,** minimum-security unit.
- **New Jersey**
- **New York**
- **North Carolina**
- **Oklahoma**
- **Oregon**
- **Pennsylvania**
- **South Carolina**
- **West Virginia-three work release** centers
- **Wisconsin**
- **District of Columbia**

Programs for Youthful Offenders

The following states cited boot camp programs providing substance abuse treatment:

- **Arkansas**
- **Florida**
- **Mississippi**
- **Texas**
- **Wisconsin**

Table 4. Treatment Programs Provided, cont.

Programs for Women

- **Alabama-community** custody in-patient program for twenty; also eight-week institutional program.
- Florida--therapeutic community.
- Illinois-therapeutic community.
- Minnesota-institutional program with follow-up.
- **Oklahoma -** 24-bed, 16-week program.
- South Carolina - 12-bed, 60-day program.
- **Vermont-therapeutic community.**
- Wisconsin-feminist-based consciousness raising program.

Programs for Racial/Ethnic Groups

Native Americans:

- **Montana-Native American Spiritual** Program support group.
- New Mexico-agency contracts with Native American organizations to provide counseling/treatment while offenders are incarcerated and on release.
- **Oregon-group counseling.**

Spanish speaking offenders:

- Connecticut - support group.
- **New Hampshire - AA and** counseling.
- **Oregon--group counseling.**

Blacks:

- Oregon-group counseling.

Programs Emphasizing Continuity of Treatment

- Colorado-eighty-hour pre-release program plus post-release program, TASC model.
- **Connecticut-FIRE** program (Facilitating Integration and Re-entry Experience).
- Florida-therapeutic communities for inmates near end of sentence, plus outpatient counseling.
- Georgia-pre-release plus community outreach.
- Illinois-outpatient counseling at work release centers; IPS for fifty high-risk parolees.
- **Kansas-community aftercare.**
- Michigan-pilot program.
- Oklahoma-TASC, work release, halfway house.
- Oregon-pre-release, parole transition.
- **Washington**
- **Wisconsin**

Other Special Programs

Programs including families:

- **Connecticut**
- **North Dakota**
- **Washington**

Programs for those in denial:

- Connecticut-support groups.

Dual diagnosis:

- Connecticut-AIDS/HIV+.
- Kansas-mentally ill.
- Wisconsin-low-functioning.

Probation/parole violators:

- Iowa--prison-based, thirty-day relapse prevention program.